PRINTED: 12/15/2014 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---|--|---|------------|--|
| | | 175151 | B. WING _ | | | 12/15/2014 | |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPITA | L SNF | | STREET ADDRESS, CITY, STAT 325 MAINE ST LAWRENCE, KS 66044 | E, ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | ((EACH CORRECTI CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY) | | |
| F 000 | INITIAL COMMENTS | | F 0 | 000 | | | |
| F 221 SS=D | The following citation Health Resurvey. 483.13(a) RIGHT TO PHYSICAL RESTRAI | | F 2 | 21 | | | |
| 22-0 | The resident has the physical restraints im | right to be free from any posed for purposes of ence, and not required to | | | | | |
| | by: The facility had a cer sample included 8 re Based upon observat interview the facility fa | ion, record review and ailed to ensure full side rails tive device for 1 of 3 (#20) | | | | | |
| | - Resident #20's adm (MDS) 3.0 dated 12/1 scored 7 (severely im Brief Interview for Me behaviors, required I bed mobility, walking extensive staff assista locomotion on the unipersonal hygiene. The resident was not stea with human assistance to standing position, value facing the opposite disurface to surface tra | imited staff assistance with in the room/corridor, ance with transfers, it, dressing, toilet use and | | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: H023101

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | STRUCTION | | E SURVEY PLETED |
|--------------------------|--|--|---------------------|--------|---|----|----------------------------|
| | | 175151 | B. WING _ | | | 12 | /15/2014 |
| | ROVIDER OR SUPPLIER | AL SNF | • | 325 MA | T ADDRESS, CITY, STATE, ZIP CODE AINE ST RENCE, KS 66044 | • | |
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| F 221 | Continued From pag | e 1 | F 2 | 221 | | | |
| | of motion, utilized a continent of urine. Tresident had no falls and had (1) non-injudid not utilize restrain. The resident's Cogn Assessment (CAA) or resident had no doct alert to self but not to the resident's Activit 12/1/14 included the therapy. The resident's Fall Country the resident was at res | walker and was always the MDS identified the //fractures prior to admission ry fall since admission and ints. ition Loss Care Area dated 12/1/14 included the umented memory loss, was to time or place. ty of Daily Living CAA dated resident received physical CAA dated 12/1/14 included isk for falls, had slid out of ission. The resident was a rassisted the resident with a bed and chair alarm to alert ttempted to transfer without colan reviewed on 12/2/24 thad impaired functional and the resident used assistive inctional mobility training and are. The resident easily lost of confused at night, attempted inimself/herself and utilized a the resident transferred with | | | | | |
| | and required staff as assistance to stand to resident had sustain admission. | was unsteady while walking sistance and required staff from a sitting position. The ed a non-injury fall since plan did not include the rails. | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED | |
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| | | 175151 | B. WING _ | | | 12/15/2014 |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIV CROSS-REFERENCE | AN OF CORRECTION /E ACTION SHOULD BE ID TO THE APPROPRIATE ICIENCY) | (X5) COMPLETION DATE |
| F 221 | was at risk for rolling impaired lower extrer utilized full bed rails i prevent rolling/sliding A nurse's note (NN) of 12:54 A.M. included to in place for safety, the himself/herself in bedwere raised per family A NN dated 12/3/14 and staff found the reson the floor next to hit the bed with his/her resident's upper (2) s | risk assessment and /24/14 included the resident out/sliding out of bed due to mity mobility and the resident in the raised position to dated 12/1/14 and timed the resident had a bed alarm the resident repositioned land the resident's bed rail by request. In and timed 12:45 A.M. In dent's bed alarm activated, resident sitting cross legged sold in the sed of light arm on the bed. The lide rails were raised, and | F2 | 221 | | |
| | resident from slipping. The resident's clinical support the facility the resident to ensure the least restrictive device. On 12/2/14 at 8:35 A and the upper (2) side position. On 12/4/14 at 7:45 A and observation reveal the raised position. On 12/3/14 at 8:10 A activated and direct conurse H were in the his | I record lacked evidence to proughly assessed the e 4 raised side rails were the | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION G | | ATE SURVEY DMPLETED |
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| F 221 | nurse H entered the laboratory staff assis stated the resident go bathroom without stacare staff O was in tresident. At 8:20 A. the resident from the Observation reveale and unsteady gait. On 12/3/14 at 12:35 and all 4 side rails worth During interview with resident's at that time all 4 side rails were from getting out of both On 12/4/14 at 9:06 A all resident's upper stated if facility staff well as the upper side considered a restraithe resident's family the resident's family the resident's lower raised side rails were on 12/4/14 at 12:55 stated the resident were from getting out of the resident were sident, the resident were formed hourly rower is staff raised all 4 of the prevent the resident bed. On 12/4/14 at 1:13 is staff D stated the resident were stated the resident bed. | resident's room and a sting the resident's roommate got out of bed and made it to aff assistance and that direct the bathroom with the M. direct care staff O assisted to bathroom via a gait belt. In the resident had a wobbly the P.M. the resident laid in bed were in a raised position. In a family member of the e, the family member stated traised to prevent the resident. | F 2 | 21 | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | IPLE CONSTRUCTION NG | | ATE SURVEY OMPLETED |
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| F 221 | _ | oor, performed hourly | F 2 | 221 | | |
| | side rails times 4 to p sliding out of bed. Li side rails in the raised considered a restrain rails prevented the re of bed. Licensed nur upper side rails were the resident was in be | d/chair alarm and utilized brevent the resident from censed staff D stated the 4 d position were not at because the raised side esident from rolling/sliding out are D stated all resident's in the raised position when ed and this resident's family II 4 side rails were to be in | | | | |
| | included side rails wh device for the resider to prevent the resider did not meet the defin The facility failed to id | nt Policy dated May 2013 nen used as an assistive nt, at the resident's request, nt from rolling out of bed nition of a restraint. dentify and thoroughly as a potential restraint. The | | | | |
| | facility further failed to methods prior to raisi per family request. 483.20(g) - (j) ASSES | o implement alternative ing the resident's side rails | F2 | 778 | | |
| | resident's status. A registered nurse m | ust conduct or coordinate | | | | |
| | assessment is compl | n professionals. ust sign and certify that the | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC' | ON SHOULD BE HE APPROPRIAT | | (X5) COMPLETION DATE | |
| F 278 | Under Medicare and willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a resident assessment penalty of not more thassessment. Clinical disagreemen material and false statement and false statement facility reported sample size included closed record. Based interview the facility for the Minimum Data Sets 53). Findings included: - The 5 day Minimum 7/22/14 revealed resipressure ulcer upon a (centimeters) cm (x) is resident required extends and the initial statement of the initial s | n and certify the accuracy of sessment. Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money nan \$5,000 for each | F 2 | 78 | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 278 | had a stage 2 pressu measured 2.1 cm x 1 The Admission Minim 7/28/14 revealed the pressure ulcer upon a cm x 1.0 cm x 0.1 cm extensive assistance bed mobility, transfer. The Pressure ulcer C 7/28/14 revealed a st coccyx present upon The discharge MDS or resident had a stage present on admission 1.5 cm x 0.2 cm. The care plan revised resident had a stage coccyx, and staff ass hours with repositioni Wound assessment or coccyx wound was a which measured 2.9 or linterview on 12/3/14 nursing staff D reveal MDS process and vo and discharge assess incorrectly. Resident with a stage 2 pressure a stage 3 pressure and procedure. | re ulcer on the coccyx which .5 cm x 0.5 cm. from x 0.5 cm. from Data Set (MDS) dated resident had a stage 3 admission that measured 1.9 and the resident required of two staff members for so and toilet use. From Area Assessment dated age 3 pressure ulcer on admission. From States and the stage 3 pressure ulcer that was a which measured 2.5 cm x From States and the stage 3 pressure ulcer on the stage 3 pressure ulcer on the stage 3 pressure ulcer on the stage 3 pressure ulcer cm x 1.4 cm x 0.15 cm. From X 1.4 cm x 0.15 cm. From X 1.4 cm x 0.15 cm. From Stage 3 pressure ulcer cm x 1.4 cm x 0.15 cm. From Stage 3 pressure ulcer cm x 1.4 cm x 0.15 cm. From X 1.4 cm x 0.15 cm. | F2 | 278 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 278 F 281 SS=D | The facility failed to a day, admission and d this resident whose p when admitted and bulcer while in the facil 483.20(k)(3)(i) SERV PROFESSIONAL STOTHE SERVICES provided | anner that maintained and federal guidelines. ccurately complete the 5 ischarge MDS accurately for ressure ulcer was a stage 2 ecame a stage 3 pressure lity. ICES PROVIDED MEET | | 278 281 | | | |
| | by: The facility identified The sample included record. Based on obs interview the facility fa that have a black box address targeted beh plan for 2 residents (# Findings included: - The 5 day Minimum 11/26/14 revealed res anticoagulants (a meantibiotics and diureti the formation and excording the care plan update information that the re (trouble sleeping), or medications that had | n Data Set (MDS) dated sident # 66 received dication given to thin blood), cs (medication to promote cretion of urine). d on 12/2/14 lacked esident had insomnia that he/she received a black box warning (a e FDA (US food and drug | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTII | PLE CONSTRUCTION 3 | | (X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | AL SNF | • | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | | | |
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| F 281 | Continued From pag | ne 8 | F 28 | 31 | | | |
| | _ | located on the label of a BW). The care plan lacked /she used side rails. | | | | | |
| | (EMAR) revealed the orders that are BBW the care plan: Lunesta (a hypnotic given for insomnia) (PO) as needed (PR order date of 11/20/14 Lotensin (an anti-hyppressure) medication (A.M.) ordered on 11 diuretic (medication excretion of urine) mon 11/21/14 which lamedication used to t P.M. ordered on 12/1 | | | | | | |
| | slept in bed with the up position. Interview on 12/4/14 staff Q stated the res | /14 at 4:25 P.M. resident top two half side rails in the at 8:04 A.M. with direct care sident voiced his/her needs d not have access for ans. | | | | | |
| | revealed nursing sta daily and revised as and side rails were r The MDS coordinate weekly. | A.M. licensed nursing staff M ff reviewed the care plans needed, he/she voiced BBW not listed on the care plan. or reviewed the care plans | | | | | |
| | On 12/4/14 at 11:02 | A.M. administrative licensed | | | | | |

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| F 281 | does not put them on voiced all the beds or were not addressed of the policy and proces for Transitional care uprovided by the facility reviewed the care plachanges in the patien lacked identification of the facility failed to it medications and side plan who received Beside rails. The electronic meresident # 67 was addressed to the plan update resident received psystaff monitored for thi lacked targeted behawhat black box warni FDA (US food and dr | ed nursing staff were plan updates and the igh risk medications, but the care plan. He/she in the floor had side rails and on the care plan. dure revised on July 2013 unit structure standards by revealed nursing staff in daily and PRN with its condition, the policy of BBW or side rails. dentify and include BBW rails in this residents care BW medications and used dical record revealed mitted on 11/26/14. d on 12/2/14 revealed the chotropic medication and is behavior, but the care plan viors. The care plan lackeding (a warning issued by the ug administration) is a life-threatening risks located | F 28 | , | |
| | (EMAR) revealed the orders that are BBW the care plan: Metoprolol (an anti-hypressure) medication mouth (PO) two times | nic medication record resident had the following and were not addressed on pertensive (elevated blood 25 milligrams (mg) by de daily with an order date of e (a diuretic (medication to | | | |

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| | | 175151 | B. WING _ | | | 12/ | 15/2014 |
| | ROVIDER OR SUPPLIER | L SNF | | 32 | REET ADDRESS, CITY, STATE, ZIP CODE 5 MAINE ST AWRENCE, KS 66044 | | |
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| F 281 | Continued From page | e 10 | F 2 | 281 | | | |
| | - | n and excretion of urine) O ordered on 11/27/14 which | | | | | |
| | Observation on 12/3/visited with tablemate | 14 at 9:10 A.M. resident 's in the dining room. | | | | | |
| | | | | | | | |
| | revealed nursing staff daily and revised as r and side rails were no | M. licensed nursing staff M freviewed the care plans needed, he/she voiced BBW of listed on the care plan. reviewed the care plans | | | | | |
| | nursing staff D reveal responsible for care p pharmacy does the hi does not put them on | olan updates and the igh risk medications, but the care plan. He/she n the floor had side rails and | | | | | |
| | for Transitional care uprovided by the facilit reviewed the care pla | ts condition, the policy | | | | | |
| | medications and side | lentify and include BBW rails in this residents care BW medications and used | | | | | |

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| F 287 F 287 SS=E | 483.20(f) ENCODIN RESIDENT ASSESS (1) Encoding Data. A completes a residen must encode the foll resident in the facility (i) Admission assess (ii) Annual assessme (iii) Significant change (iv) Quarterly review (v) A subset of items reentry, discharge, a (vi) Background (facis no admission asses (2) Transmitting data completes a residen must be capable of the System information the MDS in a format record layouts and opasses standardized the State. (3) Transmittal requires facility must electron accurate, and completes a facility formula assessment (iii) Significant correct (v) Significant correct assessment. (vi) Quarterly review | G/TRANSMITTING SMENT Within 7 days after a facility t's assessment, a facility owing information for each y: sment. ent updates. ge in status assessments. assessments. supon a resident's transfer, and death. e-sheet) information, if there essment. a. Within 7 days after a facility t's assessment, a facility transmitting to the CMS for each resident contained in that conforms to standard lata dictionaries, and that d edits defined by CMS and rements. Within 14 days after a resident's assessment, a ically transmit encoded, lete MDS data to the CMS e following: sment. ent. ge in status assessment. ction of prior full assessment. ction of prior quarterly | F 287 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE C | ONSTRUCTION | ' ' | TE SURVEY MPLETED |
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| F 287 | initial transmission of does not have an additional does not have an alternate RAI format specified by the CMS. This REQUIREMEN by: The facility identified The sample include record. Based on record. Based on recorditional does not be added to the sample include record. Based on recorditional does not be added to the sample included record. Based on recorditional does not be added to the sample included: Review of the electronal does not be added to the facility tracking record within the resident and the facility of the recording staff D reveau MDS process and has tracking on resident. The Resident Assess policy and procedure revealed the facility of the recording the recording the recording tracking on resident. | and death. ce-sheet) information, for an f MDS data on a resident that imission assessment. facility must transmit data in by CMS or, for a State which approved by CMS, in the he State and approved by T is not met as evidenced a census of 8 residents. d 8 residents and 1 closed cord review and interview the olete the entry tracking record assessment instrument (RAI), #69, #67, # 11, #38, # 68, etronic medical record and approved the facility on failed to complete an Entry in the RAI. at 9:59 A.M. administrative alled he/she completed the entry done the entry | F 287 | | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 287 | _ | conduct an Entry tracking ent, according to the RAI | F 287 | | | |
| | revealed resident # 11/23/14. The facility tracking record withi Interview on 12/3/14 nursing staff D reveal | atronic medical record 11 entered the facility on a failed to complete an Entry in the RAI. at 9:59 A.M. administrative aled he/she completed the fad never done the entry | | | | |
| | The Resident Asses policy and procedure revealed the facility process in a timely n compliance with state. The facility failed to the state of the facility failed to the facility failed to the state of the facility failed to the facility failed to the state of the facility failed to the state of the facility failed to the facility failed to the state of the state o | | | | | |
| | revealed resident # 0 11/24/14. The facility tracking record withi Interview on 12/3/14 nursing staff D reveal | at 9:59 A.M. administrative aled he/she completed the ad never done the entry | | | | |
| | | sment Instrument (RAI) e revised on July 2013 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ′ | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPIT | TAL SNF | | STREET ADDRESS, CITY, STATE, ZIP C 325 MAINE ST LAWRENCE, KS 66044 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 287 | process in a timely compliance with star The facility failed to record for this reside process. - Review of the electrovealed resident # 11/25/14. The facility tracking record with Interview on 12/3/14 nursing staff D reversident MDS process and hydracking on resident The Resident Assess policy and procedure revealed the facility process in a timely compliance with star The facility failed to | would complete the RAI manner that maintained te and federal guidelines. conduct an Entry tracking ent, according to the RAI ctronic medical record 70 entered the facility on y failed to complete an Entry in the RAI. 4 at 9:59 A.M. administrative aled he/she completed the lad never done the entry | F2 | 287 | | | |
| | revealed resident # 11/26/14. The facilit tracking record with Interview on 12/3/14 nursing staff D reve | 4 at 9:59 A.M. administrative aled he/she completed the lad never done the entry | | | | | |

| STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|---|---------------------------------|------------|
| | | 175151 | B. WING _ | | | 12/15/2014 |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPITA | L SNF | | STREET ADDRESS, CITY, STATE, ZIP OF 325 MAINE ST LAWRENCE, KS 66044 | CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIA | DATE. |
| F 287 | Continued From page | e 15 | F 2 | 87 | | |
| | policy and procedure revealed the facility was process in a timely material compliance with state. The facility failed to compliance with state. | ment Instrument (RAI) revised on July 2013 rould complete the RAI anner that maintained e and federal guidelines. onduct an Entry tracking nt, according to the RAI | | | | |
| | | 7 entered the facility on failed to complete an Entry | | | | |
| | nursing staff D reveal | at 9:59 A.M. administrative ed he/she completed the d never done the entry before. | | | | |
| | policy and procedure revealed the facility w process in a timely m | ment Instrument (RAI) revised on July 2013 rould complete the RAI anner that maintained and federal guidelines. | | | | |
| | | onduct an Entry tracking nt, according to the RAI | | | | |
| | | nission Minimum Data Set /14 identified the resident acility on 11/18/14. | | | | |
| | | nts clinical record lacked lid an entry tracking record. | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION 3 | (X3) DATE SU COMPLET | |
|--|---|--|---|---|-------------------------|----------------------------|
| | | 175151 | B. WING | | 12/15 | /2014 |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPIT | AL SNF | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 287 | During interview wit on 12/3/14 at approstated the facility did records. According to the Mintracking records are Assessment Instrumno later than entry of The facility failed to tracking record. - Resident #68's clir resident was admitted with hospice services Review of the reside evidence the facility On 12/2/14 at 8:00 A During interview with on 12/3/14 at approstated the facility did records. According to the Mintracking records are Assessment Instrumno later than entry of | A.M. the resident laid in bed. h administrative nursing staff ximately 11:00 A.M. he/she d not complete entry tracking nimum Data Set manual entry part of the Resident nent and must be completed late plus 7 calendar days. complete the required entry nical record identified the ed to the facility on 11/26/14 | F 28 | 37 | | |
| | - | closed record) clinical record | | | | |

| | 175151 | B. WING | | 12/15/2014 |
|---|---|---------------------|--|------------|
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPIT | TAL SNF | 3 | STREET ADDRESS, CITY, STATE, ZIP CODE 125 MAINE ST LAWRENCE, KS 66044 | |
| PREFIX (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | DATE |
| on 8/15/14 and disc 8/29/14. Review of the reside evidence the facility During interview with on 12/3/14 at appropriated the facility did records. According to the Minteracking records are Assessment Instrum no later than entry of the facility failed to tracking record. F 314 SS=G Based on the comparesident, the facility who enters the facility who enters the facility does not develop prindividual's clinical of they were unavoidal pressure sores recesservices to promote prevent new sores for this REQUIREMEN by: The facility reported | ents clinical record lacked did an entry tracking record. The administrative nursing staff at a must entry tracking record. The administrative nursing staff at a must entry tracking record. The administrative nursing staff at a must entry tracking record. The administrative nursing staff at a must be completed at the plus 7 calendar days. The administrative nursing staff at a must entry tracking record the Resident rent and must be completed at the plus 7 calendar days. The administrative nursing entry tracking resource assessment of a must ensure that a resident resource sores unless the condition demonstrates that ble; and a resident having enves necessary treatment and the healing, prevent infection and | F 287 | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | ULTIPLE CONSTRUCTION (X3) DAT CON | | |
|--------------------------|--|---|---------------------|---|---------------|--|
| | | 175151 | B. WING | | 12/15/2014 | |
| | ROVIDER OR SUPPLIER | TAL SNF | 31 32 LA | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION | |
| F 314 | #53's (closed record size and stage. Findings included: - The 5 day Minimu 7/22/14 revealed re pressure ulcer upor (centimeters) cm (x resident required ex staff members for b toilet use. The Pressure ulcer 7/28/14 revealed a coccyx present upo The discharge MDS resident had a stage present on admission 1.5 cm x 0.2 cm. Interview on 12/3/14 nursing staff D reve MDS process and wand discharge asses incorrectly. Resident with a stage 2 pressident had a stage 2 pressident had a stage 3 president had a stage 3 president had a stage 2 hours with repositive to the stage 2 hours with repositive size and staff we 2 hours with repositive size and stage 3 president had a stage coccyx, and staff we 2 hours with repositive size and stage 3 president had a stage coccyx, and staff we 2 hours with repositive size and stage 3 president had a stage coccyx, and staff we 2 hours with repositive size and stage 3 president had a stage coccyx, and staff we 2 hours with repositive size and stage 3 president had a stage coccyx, and staff we 2 hours with repositive size and stage 3 president had a stage coccyx, and staff we 2 hours with repositive size and stage 3 president had a stage coccyx, and staff we 2 hours with repositive size and stage 3 president had a stage 3 president had 3 presiden | am Data Set (MDS) dated sident # 53 had a stage 3 in admission that measured 2.0 in by 1.1 cm x 0.1 cm. The stensive assistance of two led mobility, transfers and admission. Care Area Assessment dated stage 3 pressure ulcer on admission. Cated 8/15/14 revealed the least of the stage 3 pressure ulcer that was on which measured 2.5 cm x A at 9:59 A.M. administrative alled he/she completed the roiced the 5 day, admission assment were coding at #53 came into the facility sure ulcer and while in facility or lessure ulcer. Led on 8/12/14 revealed the least of a 3 pressure ulcer on the least of assist the resident every lessure ulcer. | F 314 | | | |
| | of facility revealed t | he resident had a stage 2 ne coccyx which measured 2.1 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | IPLE CONSTRUCTI | | | E SURVEY PLETED |
|---|--|--|---------------------|---------------------------------------|---|----|----------------------------|
| | | 175151 | B. WING _ | | | 12 | /15/2014 |
| | ROVIDER OR SUPPLIER | L SNF | | STREET ADDRE 325 MAINE ST LAWRENCE, | | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EA | PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD ISS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 314 | Continued From page | e 19 | F3 | 14 | | | |
| | coccyx wound was a which measured 2.5 wound assessment of coccyx wound was a which measured 2.9 wound was a which measured 2.9 wound was a which measured 2.9 wound was a recommendation of again on 8/4/14 weigh declined continue ensured working the physic 7/15/14 through 8/15, had a stage 2 pressure ulcer worse stage 3 pressure ulcer worse stage 3 pressure ulcer a change in treatment got worse. Interview on 12/3/14 nursing staff D reveal nurse and charted on which was not done of stated the physician was notified the pressure wound, | ian progress notes dated /14 revealed the resident re ulcer during his/her stay. cumentation that the facility | | | | | |
| | The policy and proce | dure for wound care /28/14did not addresswhat | | | | | |

| , , | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|--------------------|---|-------------------------------------|-------------------------------|
| | | 175151 | B. WING | | | 12/15/2014 |
| | ROVIDER OR SUPPLIER | L SNF | · | STREET ADDRESS, CITY, STATE, ZI 325 MAINE ST LAWRENCE, KS 66044 | P CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | ACTION SHOULD BE O THE APPROPRIA | |
| F 314 | The clinical record lac worsening of the pres The record also lacke | e 20 are wound that got worse. beked evidence to show the sure ulcer was unavoidable. and evidence the physician oressure ulcer got larger and | F | 314 | | |
| F 323 SS=D | 483.25(h) FREE OF A HAZARDS/SUPERVI The facility must ensu environment remains as is possible; and ea | SION/DEVICES ure that the resident as free of accident hazards | F | 323 | | |
| | by: The facility had a cer sample included 8 res Based upon observat interview the facility fa | is not met as evidenced nsus of 8 residents. The sidents and 1 closed record. ion, record review and ailed to provide effective esident (#20) to minimize | | | | |
| | (MDS) 3.0 dated 12/1 scored 7 (severely im Brief Interview for Me behaviors, required I bed mobility, walking extensive staff assista | imited staff assistance with in the room/corridor, | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTII A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------------|---|-------------------------------|--|
| | | 175151 | B. WING | | 12/15/2014 | |
| | ROVIDER OR SUPPLIER | AL SNF | • | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE COMPLETION | |
| F 323 | the resident was not stabilize with human from seated to stand around and facing th walking and surface MDS recorded the relimitation in range of was always continent identified the resident to admission and had admission. The resident's Cognit Assessment (CAA) or resident had no docutalert to self but not to the resident was at risped one time since at a safety concern, stambility and utilized staff if the resident at staff assistance. The resident's Injury 11/18/14 and 12/2/14 risk for fall, staff taughow to use call system and activity limitation resident's call light, of frequently used pers resident's reach, locked the stand activity reach, locked the staff and the staff activity seach, locked the staff activity seach, locked the staff activity reach, locked the staff activity seach, locked the staff activity seach activi | giene. The MDS identified steady, was only able to assistance when moving ing position, walking, turning e opposite direction while to surface transfers. The esident had no functional motion, utilized a walker and t of urine. The MDS at had no falls/fractures prior d (1) non-injury fall since tion Loss Care Area lated 12/1/14 included the amented memory loss, was be time or place. By of Daily Living CAA dated resident received physical the resident was aff assisted the resident with a bed and chair alarm to alert attempted to transfer without the resident was at the the resident and family and, how to operate the bed | F 33 | 23 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUC A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|---------------------|--|--|-------------------------------|--|--|
| | | 175151 | B. WING _ | | | 12/15/2014 | | |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPITA | L SNF | | STREET ADDRESS, CITY, STATE, 325 MAINE ST LAWRENCE, KS 66044 | ZIP CODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | ((EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE | | |
| F 323 | functional height whee provided. Staff enco for help as needed an non-skid footwear wha fall prevention sign the resident wore a fastaff performed hourl was awake, staff stay resident used the corabed alarm/chair alaresident's need for rephysical/occupational consultation. The resident's care pincluded the resident mobility, staff ensure devices, received fur restorative nursing cahis/her balance, was to get out of bed by hed/chair alarm. The assistance of 1 staff, and required staff assisting position. The ron-injury fall since a The resident was one fall prevention sign of all risk identification resident on an hourly assistance hourly whas the resident when he replaced the resident. A nurses' note (NN) of | dent's bed was at the lowest on direct care was not uraged the resident to call and the resident wore uen out of bed. Staff placed on the resident's room door, all risk identification band, by check when the resident wed with resident when the mode, the resident utilized rm. Staff assessed the storative nursing, I therapy and a pharmacist lan reviewed on 12/2/24 had impaired functional did the resident used assistive ctional mobility training and are. The resident easily lost confused at night, attempted imself/herself and utilized a resident transferred with was unsteady while walking sistance to stand from a esident had sustained a dmission. It updated 12/2/14 included strict fall precautions, had a n his/her room door, wore a band, staff checked on the basis, offered toileting ile awake, staff stayed with /she used the bathroom and | F3 | 323 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) N IDENTIFICATION NUMBER: A. BU | | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|---|---|----------|-------------------------------|--|
| | | 175151 | B. WING _ | | | 12/15/2014 | |
| | ROVIDER OR SUPPLIER | AL SNF | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE | |
| F 323 | Continued From pag | e 23 | F3 | 23 | | | |
| | via a wheelchair and resident had some or only alert to self. Stafall band identification resident's safety need. A NN dated 11/23/14 included at 11:30 P.N help. The resident latthe floor. Two staff rivia a gait bed. Staff alarm and the bed all. An injury risk assess 12/2/14 timed 9:37 A last fall risk consultation 11/24/14. The resident precautions which in on the door, fall risk checks by staff, staff the resident was away the resident when/sh. A NN dated 12/3/14 documented the resident when/sh. A NN dated 12/3/14 documented the resident when/sh. A ninjury risk assess 12/3/14 timed 12:59 had 2 or more falls were sident last fall was resident last fall was | acute care staff reported the onfusion at night and was aff placed a bed alarm and a n bracelet to alert staff of the ds. and timed 11:55 P.M. M. the resident called for aid on his/her abdomen on eturned the resident the bed replaced the resident's bed | | | | | |
| | band, hourly checks | ne door, fall risk identification by staff, staff offered hourly sident was awake and staff | | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | DATE SURVEY COMPLETED |
|--------------------------|---|---|---------------------|--|----------|----------------------------|
| | | 175151 | B. WING | | | 12/15/2014 |
| | ROVIDER OR SUPPLIER | AL SNF | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 323 | | e 24 sident when/she used the | F 32 | 3 | | |
| | On 12/3/14 at 8:10 A activated and direct nurse H were in the licensed nurse H ental a laboratory staff ass roommate stated the made it to bathroom that direct care staff the resident. At 8:20 assisted the resident | e resident got out of bed and without staff assistance and O was in the bathroom with O A.M. direct care staff O t from the bathroom via a gait vealed the resident had a | | | | |
| | the resident was at r hourly rounds, ensur was within reach, off ensured the resident ensured the resident plugged in all the tim not activate the call I On 12/4/14 at 12:55 stated the resident w performed hourly rou | P.M. licensed nurse I stated isk for falls. Staff performed red the resident's call light fered the resident the urinal, its trash can was in reach and its bed/chair alarm was be because the resident did ight. P.M. direct care staff L was at risk for falls. Staff unds, offered toileting to the dent had a bed alarm. | | | | |
| | the resident was at r wore a fall risk brace his/her door, perform | P.M. licensed staff D stated isk for falls. The resident elet, had a fall risk sign on ned hourly rounds, utilized a utilized side rails times 4 to | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ` ′ | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|---|-------------------------------|
| | | 175151 | B. WING | | 12/15/2014 |
| | ROVIDER OR SUPPLIER | AL SNF | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 25 MAINE ST AWRENCE, KS 66044 | , |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION |
| F 323 F 329 SS=D | prevent the resident The facility's Fall Pre April 2013 included i interventions to min falls. The facility failed to timely interventions of falls. 483.25(I) DRUG RE UNNECESSARY DE Each resident's drug unnecessary drugs. drug when used in e duplicate therapy); o without adequate mo indications for its use | evention Policy approved in mplementation of imize the potential risk for amplement effective and for this resident with a history GIMEN IS FREE FROM RUGS Tregimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate e; or in the presence of | F 323 | | |
| | should be reduced of combinations of the Based on a compreheresident, the facility who have not used a given these drugs ur therapy is necessary as diagnosed and do record; and resident drugs receive gradus behavioral interventi | ces which indicate the dose or discontinued; or any reasons above. Inensive assessment of a must ensure that residents antipsychotic drugs are not alless antipsychotic drug or to treat a specific condition ocumented in the clinical so who use antipsychotic all dose reductions, and ons, unless clinically in effort to discontinue these | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|-----------------------------|--|-------------------------------|
| | | 175151 | B. WING | | 12/15/2014 |
| | ROVIDER OR SUPPLIER | IL SNF | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE COMPLETION |
| F 329 | Continued From page | e 26 | F 32 | 9 | |
| | by: The facility identified The sample size included record. Based review and interview target behaviors for repsychotropic medicate. | a census of 8 residents. uded 8 residents and 1 l on observation, record the facility failed to identify esidents who received tion for 4 residents (# 66, # f 5 residents sampled. | | | |
| | 11/26/14 revealed resanticoagulants (a me | dication given to thin blood), ics (medication to promote cretion of urine). | | | |
| | Review of the electro revealed the resident hypnotic (a psychotro insomnia) 1 milligram needed (PRN) daily f date of 11/20/14. The medication 11/20/14, | nic medication record had an order for Lunesta (a opic medication) given for (mg) by mouth (PO) as for sleep and had an order resident received this | | | |
| | Lunesta revealed the medication on 11/28/ flow sheet for Lunest and was not put into | or monitoring flow sheet for resident had received this 14. The behavior monitoring a lacked targeted behaviors effect until 11/28/14, 8 days was ordered for the resident. | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | LE CONSTRUCTION | | DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|---|-----------|----------------------------|
| | | 175151 | B. WING | | | 12/15/2014 |
| | ROVIDER OR SUPPLIER | AL SNF | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | IATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 329 | Con 12/3/14 at 8:39 A has never slept well naps during the day. Interview on 12/4/14 staff Q stated the resappropriately, and di Con 12/4/14 at 9:06 A revealed behavior minto effect as soon as when the medication all behaviors and if a Pfelectronic medical remonitoring flow sheet with targexpected the behavior reflect the EMAR. On 12/4/14 at approximately at approximately at approximately at a proximately at | vior monitoring flowsheet for steed behaviors. /14 at 4:25 P.M. resident a.M. resident stated he/she at night and preferred to take at 8:04 A.M. with direct care sident voiced his/her needs d take naps during the day. a.M. licensed nursing staff M onitoring sheets were put a resident was admitted or was ordered. He/she stated ng flow sheets had target RN medication was given the cord (EMAR) and behavior | F 32 | | | |
| | The policy and proce | edure revised on April 2011 | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|--|-------------------------------|
| | | 175151 | B. WING | | 12/15/2014 |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPIT | AL SNF | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY) | D BE COMPLETION |
| F 329 | facility revealed nurse behavior monitoring behaviors to be more upon initiation of a revolution would document on times this behavior. The facility failed to that needed monitor received a psychotron of the electronic monitor received a psychotron of the electronic monitor resident # 67 was as the care plan update resident experience for this behavior. Review of the electronic medication used for reaction characteriz uncertainty and irrate (mg) by mouth (PO) three times a day with the electronic medication that the electronic medication used for reaction characterize uncertainty and irrate (mg) by mouth (PO) three times a day with the electronic medication that the electronic medication used for reaction characterize uncertainty and irrate (mg) by mouth (PO) three times a day with the electronic medication used for reaction characterized (mg) by mouth (PO) three times a day with the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication used for reaction characterized (mg) by mouth (PO) three times and the electronic medication characterized (mg) by mouth (mg) three times and the electronic medication characterized (mg) three times (mg) three t | ring flow sheet provided by the sing staff would initiate a flow sheet which included nitored upon admission or nedication. Nursing staff this flow sheet the number of occurred. identify specific behaviors ring for this resident who opic medication. edical record revealed dmitted on 11/26/14. Ited on 12/2/14 revealed the d anxiety and staff monitored onic medication record anxiety (mental or emotional ed by apprehension, ional fear) 0.25 milligrams as needed (PRN) for anxiety ith an order date of 11/26/14. | F 32 | , | |
| | flow sheets lacked to Observation on 12/3 visited with tablema Interview on 12/4/14 staff Q stated the reappropriately, and h | November and December argeted behaviors for Xanax. 8/14 at 9:10 A.M. resident te's in the dining room. I at 8:04 A.M. with direct care sident voiced his/her needs ad no behaviors. A.M. licensed nursing staff M | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|--|-------------------------------|
| | | 175151 | B. WING | | 12/15/2014 |
| | ROVIDER OR SUPPLIER | AL SNF | 3: | TREET ADDRESS, CITY, STATE, ZIP CODE 25 MAINE ST AWRENCE, KS 66044 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION |
| F 329 | into effect as soon a when the medication all behavior monitorio behaviors. On 12/4/14 at 11:02 nursing staff D reveather resident put into flow sheets with target on 12/4/14 at approconsultant GG state staff to identify target monitoring flow sheet staff to identify target monitoring flow sheet he/she stated since are here such a shoreview the behavior. The policy and procefor behavior monitoring behavior monitoring behavior stobe more upon initiation of an would document on times this behavior of that needed monitor ordered a psychotro. The 5 day Minimut 11/28/14 revealed rehypnotics (a medication emotional reaction of emotio | an a resident was admitted or a was ordered. He/she stated and flow sheets had target A.M. administrative licensed aled the nurse who admitted effect behavior monitoring et behaviors listed. Aximately 1:20 P.M. pharmacy dependent of the expected nursing to behaviors and the behavior ets to reflect the EMAR. The residents at this facility at time pharmacy staff try to amonitoring sheets weekly. Addure revised on April 2011 and flow sheet which included intored for upon admission or needication. Nursing staff this flow sheet the number of occurred. Adentify specific behaviors and for this resident who was pic medication. The Data Set (MDS) dated assident #70 received tion used for sleep) and an used for anxiety (mental or | F 329 | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTI | ON | (X3) DATE COMP | SURVEY PLETED |
|--------------------------|--|--|---------------------|---------------------------------------|---|-------------------|----------------------------|
| | | 175151 | B. WING _ | | | 12/ | 15/2014 |
| | ROVIDER OR SUPPLIER | L SNF | • | STREET ADDRE 325 MAINE ST LAWRENCE, | SS, CITY, STATE, ZIP CODE KS 66044 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EA | PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD E SS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 329 | Continued From page | e 30 | F3 | 29 | | | |
| | resident received psy lacked information or | d on 12/2/14 revealed the chotropic medications but specific psychotropic ent received and targeted | | | | | |
| | revealed the resident anti-anxiety (mental of characterized by appirrational fear) medical mouth (PO) as needed for anxiety with an orresident received this 11/25/14-12/2/14. An (a psychotropic medical milligram (mg) by modaily for sleep and ha | rehension, uncertainty and ation)) 1 milligram (mg) by ed (PRN) every four hours der date of 11/25/14. The medication daily order for Ambien (a hypnotic cation) given for insomnia) 5 uth (PO) as needed (PRN) ed an order date of 11/25/14. It this medication 11/26/14, | | | | | |
| | sheet for Ativan revea received this medicat 11/29/14. The behavi Ativan lacked targete | ion on 11/28/14 and or monitoring flow sheet for d behaviors, and was not /28/14, 4 days after the | | | | | |
| | sheet for Ambien revereceived this medicate behavior monitoring for targeted behaviors, a | low sheet for Ambien lacked nd was not put into effect after the medication was | | | | | |
| | Review of the Decem | ber behavior monitoring flow | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|------------------------------|---|-------------------------------|
| | | 175151 | B. WING | | 12/15/2014 |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPITA | AL SNF | 3 | STREET ADDRESS, CITY, STATE, ZIP CODE 125 MAINE ST LAWRENCE, KS 66044 | · |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE COMPLETION |
| F 329 | received Ativan and a medications lacked of behaviors. Observation on 12/1, voiced complaints of nursing staff gave his he/she asked. Interview on 12/4/14 staff Q stated the resappropriately, and diverbally abusive at ti On 12/4/14 at 9:06 A revealed behavior minto effect as soon as when the medication all behavior monitoring behaviors and if a Prelectronic medical remonitoring flow sheet On 12/4/14 at 11:02 nursing staff D reveathe resident put into flow sheets with targe expected the behavior effect the EMAR. On 12/4/14 at approximately, and diverbally abusive at time to the shade of the s | Ambien revealed the resident Ambien on 12/1/14, both documentation for targeted //14 at 11:33 A.M. resident pain and he/she stated m/her pain medications when at 8:04 A.M. with direct care sident voiced his/her needs splayed agitation and was mes. A.M. licensed nursing staff Monitoring sheets were put a resident was admitted or was ordered. He/she stated ng flow sheets had target RN medication was given the cord (EMAR) and behavior | F 329 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | PLE CONSTRUCTION IG | | TE SURVEY MPLETED |
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| | | 175151 | B. WING _ | | , | 12/15/2014 |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPITA | L SNF | | STREET ADDRESS, CITY, STATE, ZIP COI 325 MAINE ST LAWRENCE, KS 66044 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETION DATE |
| F 329 | for behavior monitoring facility revealed nursi behavior monitoring for behaviors to be monitoring to behaviors to be monitoring to behaviors to be monitoring to the facility failed to interest the resident was admitted. - Review of resident at the resident was admitted. | dure revised on April 2011 ng flow sheet provided by the ng staff would initiate a flow sheet which included tored for upon admission or edication. Nursing staff his flowsheet the number of ccurred. dentify specific behaviors ng for this resident who pic medication. | F3 | 29 | | |
| | staff monitored the repain medications as president received hos. The resident's care phad a Black Box War alert individuals and pany important safety side effects or life three Review of the resider Administration Recort 12/3/14 included the orders to receive Tyle suppository every 4 h | esident for pain, administered obysician ordered and the spice services. Ilan did not include Tylenol ning (BBW-a warning to nealthcare provider about concerns, such as serious eatening risk. Int's Medication d (MAR) from 11/26/14 to resident had physician's enol 650 milligrams (mg) nours, 650 mg (2) tablets led for pain/fever and do not | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|---|---|-------------------------|--|-------------------------------|
| | | 175151 | B. WING | | 12/15/2014 |
| | ROVIDER OR SUPPLIER E MEMORIAL HOSPITA | L SNF | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | BE COMPLETION |
| F 329 | Continued From page | ÷ 33 | F 32 | 9 | |
| | The resident's MAR of BBW. | lid not identify Tylenol had a | | | |
| | On 12/2/14 at 8:00 A. his/her bed. | M. the resident laid in | | | |
| | staff D stated BBW w | A.M. administrative nursing ere included on the ot on the resident's care | | | |
| | the facility listed haza | - | | | |
| | Tylenol had a black b severe liver injury and | a.gov http://www.fda.gov ox warning of potential for allergic and of the face, mouth, and hing, itching, or rash). | | | |
| | receiving regular stre | manufacturers for individuals ngth Tylenol (325 mg) the exceed 3 grams in 24 hours. | | | |
| F 428 SS=D | exceed 3 grams of Ty failed to monitor for se | GIMEN REVIEW, REPORT | F 42 | 8 | |
| | | each resident must be e a month by a licensed | | | |
| | The pharmacist must | report any irregularities to | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|---------------------|---|-------------------------------|
| | | 175151 | B. WING | | 12/15/2014 |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPITA | L SNF | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | · |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE COMPLETIC |
| F 428 | the attending physicia | e 34 an, and the director of ports must be acted upon. | F 4: | 28 | |
| | by: The facility identified The sample size inclucion closed record. Based review and interview failed to notify the factoresidents who receive were not listed on the | a census of 8 residents. uded 8 residents and 1 on observation, record the consulting pharmacist cility that target behaviors for ed psychotropic medication behavioral monitoring flow s (# 66, # 67, # 70) of 5 | | | |
| | 11/26/14 revealed resanticoagulants (a me antibiotics and diuretithe formation and except the formation that the resident (trouble sleeping). Review of the electrorevealed the resident hypnotic (a psychotroinsomnia) 1 milligram needed (PRN) daily findate of 11/20/14. The | dication given to thin blood), cs (medication to promote cretion of urine). | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ONSTRUCTION | | SURVEY PLETED |
|--------------------------|--|--|---------------------|-----|---|----|----------------------------|
| | | 175151 | B. WING _ | | | 12 | /15/2014 |
| | ROVIDER OR SUPPLIER CE MEMORIAL HOSPITA | L SNF | | 325 | EET ADDRESS, CITY, STATE, ZIP CODE MAINE ST WRENCE, KS 66044 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | × | PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 428 | Continued From pag | e 35 | F4 | 128 | | | |
| 1 420 | Review of the behavicular tunesta revealed the medication on 11/28/ flow sheet for Lunest and was not put into after the medication of the December behave Lunesta lacked target. Observation on 12/2/ slept while in bed. On 12/3/14 at 8:39 A has never slept well an aps during the day. Interview on 12/4/14 staff Q stated the resappropriately, and did on 12/4/14 at 9:06 A revealed behavior mointo effect as soon as when the medication all behaviors and if a PF | or monitoring flow sheet for resident had received this 14. The behavior monitoring a lacked targeted behaviors effect until 11/28/14, 8 days was ordered for the resident. vior monitoring flowsheet for ted behaviors. 14 at 4:25 P.M. resident .M. resident stated he/she at night and preferred to take at 8:04 A.M. with direct care ident voiced his/her needs id take naps during the day. .M. licensed nursing staff Monitoring sheets were put a resident was admitted or was ordered. He/she stated ing flow sheets had target RN medication was given the cord (EMAR) and behavior | | 128 | | | |
| | nursing staff D revea the resident put into flow sheets with targe | A.M. administrative licensed led the nurse who admitted effect behavior monitoring et behaviors listed. He/she or monitoring flow sheet to | | | | | |
| | | imately 1:20 P.M. pharmacy he/she expected nursing | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|--|-----|-------------------------------|--|
| | | 175151 | B. WING _ | | | 12/ | 15/2014 | |
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPITAL SNF | | | | STREET ADDRESS, O 325 MAINE ST LAWRENCE, KS | CITY, STATE, ZIP CODE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | (EACH (| VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 428 | monitoring flow sheet He/she stated since the are here such a short review the behavior of the policy and proces an approval date of the facility revealed the princluded monitoring a response to medicate. The pharmacy consuffacility for this resident medication that lacked - The electronic meresident # 67 was add. The care plan update resident experienced for this behavior. | behaviors and the behavior is to reflect the EMAR. The residents at this facility it time pharmacy staff try to monitoring sheets weekly. It dure for medication use with May 2014, provided by the charmacists activities and assessing patient on therapy. Itant failed to notify the monitored trageted behaviors. Idical record revealed mitted on 11/26/14. It do n 12/2/14 revealed the anxiety and staff monitored anxiety and record thad an order for Xanax (a anxiety (mental or emotional) | F | 28 | DEFICIENCY) | | | |
| | uncertainty and irration (mg) by mouth (PO) at three times a day with Review of the behaving Xanax revealed the Normal flow sheets lacked to the Normal flow sheets l | onal fear) 0.25 milligrams as needed (PRN) for anxiety an an order date of 11/26/14. or monitoring flow sheet for November and December rgeted behaviors for Xanax. 14 at 9:10 A.M. resident be's in the dining room. at 8:04 A.M. with direct care | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|--|--------------------------------|-------------------------------|--|
| | | 175151 | B. WING | | | 2/15/2014 | |
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPITAL SNF | | | | STREET ADDRESS, CITY, STATE, ZIP CO 325 MAINE ST LAWRENCE, KS 66044 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 428 | Continued From pag staff Q stated the res appropriately, and ha | ident voiced his/her needs | F 4. | 28 | | | |
| | revealed behavior meinto effect as soon as when the medication all behavior monitorin behaviors. On 12/4/14 at 11:02 nursing staff D revealed to soon as when the medication as when the medication are soon as which are soon as when the medication are soon as when the medication are soo | .M. licensed nursing staff M conitoring sheets were put as a resident was admitted or was ordered. He/she stated and flow sheets had target A.M. administrative licensed led the nurse who admitted | | | | | |
| | On 12/4/14 at approximate consultant GG stated staff to identify target monitoring flow shee He/she stated since are here such a short | effect behavior monitoring et behaviors listed. simately 1:20 P.M. pharmacy defined he/she expected nursing to behaviors and the behavior to the to reflect the EMAR. The residents at this facility to monitoring sheets weekly. | | | | | |
| | an approval date of Nacility revealed the p | dure for medication use with May 2014, provided by the charmacists activities and assessing patient on therapy. | | | | | |
| | facility for this reside | ultant failed to notify the not who recieved psychotropic ed targeted behaviors. | | | | | |
| | 11/28/14 revealed re hypnotics (a medicat anxiety (a medication emotional reaction of | ion used for sleep) and n used for anxiety (mental or | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|--|--|-----|---|-------------------------------|----------------------------|
| | | 175151 | B. WING | | | 12/15/2014 | |
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPITAL SNF | | | • | 325 | REET ADDRESS, CITY, STATE, ZIP CODE 5 MAINE ST WRENCE, KS 66044 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 428 | Continued From page medication. | ge 38 red on 12/2/14 revealed the | F | 428 | | | |
| | resident received ps lacked information of | sychotropic medications but on specific psychotropic dent received and targeted | | | | | |
| | revealed the resider anti-anxiety (mental characterized by ap irrational fear) medic mouth (PO) as need for anxiety with an oresident received th 11/25/14-12/2/14. A (a psychotropic med milligram (mg) by m daily for sleep and h | n order for Ambien (a hypnotic dication) given for insomnia) 5 outh (PO) as needed (PRN) and an order date of 11/25/14. and this medication 11/26/14, | | | | | |
| | sheet for Ativan reverse received this medica 11/29/14. The behave Ativan lacked target | mber behavior monitoring flow ealed the resident had ation on 11/28/14 and vior monitoring flow sheet for ed behaviors, and was not 1/28/14, 4 days after the d this medication. | | | | | |
| | sheet for Ambien re- received this medica behavior monitoring targeted behaviors, | mber behavior monitoring flow vealed the resident had ation on 11/29/14. The flow sheet for Ambien lacked and was not put into effect after the medication was lent. | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--|---|-------------------------------|---|
| | | 175151 | B. WING | | 12/15/2014 | |
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPITAL SNF | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 325 MAINE ST LAWRENCE, KS 66044 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETIO | N |
| F 428 | Continued From page | e 39 | F 428 | 3 | | |
| | sheet for Ativan and A received Ativan and A medications lacked d behaviors. Observation on 12/1/ | her behavior monitoring flow Ambien revealed the resident Ambien on 12/1/14, both ocumentation for targeted | | | | |
| | | pain and he/she stated n/her pain medications when | | | | |
| | staff Q stated the res | at 8:04 A.M. with direct care ident voiced his/her needs splayed agitation and was nes. | | | | |
| | revealed behavior mo into effect as soon as when the medication all behavior monitorin behaviors and if a PR | M. licensed nursing staff M onitoring sheets were put a resident was admitted or was ordered. He/she stated g flow sheets had target N medication was given the cord (EMAR) and behavior is would reflect this. | | | | |
| | nursing staff D reveal the resident put into e flow sheets with targe | A.M. administrative licensed ed the nurse who admitted effect behavior monitoring et behaviors listed. He/she or monitoring flow sheet to | | | | |
| | consultant GG stated staff to identify target monitoring flow sheet He/she stated since t are here such a short | imately 1:20 P.M. pharmacy he/she expected nursing behaviors and the behavior s to reflect the EMAR. he residents at this facility time pharmacy staff try to nonitoring sheets weekly. | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 175151 | B. WING | | | 12/15/2014 | |
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPITAL SNF | | | 3 | TREET ADDRESS, CITY, STATE, ZIP CODE 25 MAINE ST AWRENCE, KS 66044 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 428 | 8 Continued From page 40 | | F | 428 | | | |
| F 441 | facility for this resider medication that lacke The facility failed to ic that needed monitoring received a psychotropy | dentify specific behaviors ag for this resident who | F | 441 | | | |
| SS=F | SPREAD, LINENS The facility must esta Infection Control Prog safe, sanitary and con | blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission | | | | | |
| | (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | IPLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|---------------------|---|-----------------------------------|-------------------------------|--|
| | | 175151 | B. WING _ | | | 2/15/2014 | |
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPITAL SNF | | | | STREET ADDRESS, CITY, STATE, ZIP (325 MAINE ST LAWRENCE, KS 66044 | CODE | | |
| (X4) ID PREFIX TAG | | | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| F 441 | transport linens so a infection. This REQUIREMEN by: The facility had a coupon observation and to ensure linens were findings included: On 12/4/14 house facility only laundered residents with a diagon (contagious bacterials smelling frequent both infection). | cated by accepted e | F 4 | | | | |
| | the facility's washer On 12/4/14 at 9:15 A stated the facility did than 120 degrees. If at that time stated the washing the curtains hygienically cleaned On 12/4/14 at 9:20 A the facility placed blees. | A.M. the water temperature of measured 123.4 degrees. A.M. maintenance staff Z I not send out water greater Housekeeping staff Y present the facility used bleach when to ensure the curtains were to ensure the curtains were. A.M. housekeeping Y stated each in the dispensing unit of the shing the curtains but he/she | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|--|--|--|-------------------------------|--|
| | | 175151 | B. WING _ | | | 12/15/2014 | |
| NAME OF PROVIDER OR SUPPLIER LAWRENCE MEMORIAL HOSPITAL SNF | | | • | STREET ADDRESS, CITY, STATE, 325 MAINE ST LAWRENCE, KS 66044 | ZIP CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRECTIVE CROSS-REFERENCED | N OF CORRECTION E ACTION SHOULD BE I TO THE APPROPRIATE CIENCY) | (X5) COMPLETION DATE | |
| F 441 | Housekeeping staff Y have a policy regarding laundry nor did the famanufacturer of the water methods to use to proproducts. | unt of bleach staff placed. stated the facility did not ng processing of on-site cility have anything from the vasher regarding appropriate oduce hygienically clean nsure the privacy curtains | F | 141 | | | |